Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: METHODIST DALLAS MEDICAL CENTER 4040 N CENTRAL EXPRESSWAY SUITE 800 DALLAS TX 75204	MFDR Tracking #: M4-10-3014-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: AMERISURE MUTUAL INSURANCE CO Rep Box #: 47	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "The claim should be paid according to the Medicare Expected Reimbursement X 200% for outpatient services."

Principle Documentation:

1. DWC 60 package

Total Amount Sought: $44,965.73

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "In response to Methodist Health System dispute of reimbursement for outpatient services 10.23.09 MCMC LLC has recommended payment in the amount of $11,456.49 per TDI/DWC Fee MAR. RULE §134.403 Hospital Facility Fee Guideline—Outpatient. No additional reimbursement is due. The bill has been paid per TDI/DWC maximum allowable reimbursement."

Principle Documentation:

1. Response package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
12/23/09	Hospital Outpatient Surgical Services	$5,728.245 (APC+Outlier) x 200% = $11,456.49 (MAR) Respondent Paid $11,456.49	$44,965.73	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

1. The disputed services were denied or reduced by the insurance carrier based upon:

   Explanation of benefits dated 12/08/09 noted claim reduction codes:
   - 97 — PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
   - W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.

   Explanation of benefits dated 02/10/10 noted claim reduction code:
   - 193 — ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.

2. Division rule at 28 TAC §134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables."

3. Pursuant to Division rule at 28 TAC §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent."

4. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
   (1) No documentation was found to support a contractual agreement between the parties to this dispute;
   (2) MAR can be established for these services; and
   (3) Separate reimbursement for implantables was NOT requested by the requestor.

5. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.

6. Consequently, reimbursement will be calculated in accordance with division rule at 28 TAC §134.403(f)(1)(A) as follows:

   The APC Medicare facility-specific reimbursement amount including outliers payments is $5,728.245. $5,728.245 multiplied by 200% = $11,456.49

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 TAC Rule §134.403, §133.307, §133.305

PART VII: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

		September 21, 2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
	Mary Landrum	
Authorized Signature	Director, Health Care Business Management	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.